Center for
Pain Medicine

REFERRAL

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Cell Number: _____

Primary Insurance: _____

Secondary Insurance:_____

DIAGNOSIS: _____ Work Injury? ☐ Yes ☐ No

Reason for referral:

☐ Consult and treatment

☐ Procedure only:

__ Epidural Steroid injection
__ Transforaminal Epidural Injection
__ Selective Nerve Root Block
__ Sacroiliac Joint Injection
__ Medial Branch Blocks
__ Facet Joint Block
__ Radiofrequency ablation
__ Occipital Nerve Block
__ Intercostal Nerve Block
__ Botox Injections
__ Hip, Shoulder, Knee Injection
__Other: _____

__Trial/ Implant of Spinal Cord Stimulator
__Trial/ Implant Pain Pump
__Trial/ Implant Baclofen Pump
__Trial/Implant of DRG Stimulator
__Trial/Implant of PNS Stimulator
__Sacroiliac Joint Fusion
__MILD Procedure
__Basivertebral Nerve Ablation (Intracept)
__Minuteman

Referring Provider: _____
Phone Number: _____
Fax Number: _____

Please include office notes and imaging reports relating to referred condition

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https://centerforpainfargo.com/